STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505483	A. BUILDING _____ B. WING _____	C 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Alaska Gardens Health and Rehab on 10/16 & 10/17/2013. The sample included 7 residents out of a census of 103. The sample included 3 current residents and the records of 4 former residents.

The following are complaints investigated as part of this survey:

#2885128
#2882539
#2885126
#2889606
#2885470

The survey was conducted by:

[redacted] RN, MSN

The surveyor is from:

Department of Social and Health Services
Aging and Long-Term Support Administration
Division of Residential Care Services
District 3, Unit B
PO Box 45819, MS: N27-24
Olympia, WA 98504-5819

Telephone: (253) 983-3800
Fax: (253) 589-7240

Rhonda Grimes 10/22/13
Residential Care Services Date

DISCLAIMER CLAUSE

PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathi Scott	ED	10/30/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505483	A. BUILDING _____ B. WING _____	C 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview it was determined the facility failed to consistently follow the care plan for the use of an assistive device and/or the number of staff recommended for bed mobility for 2 of 5 residents (current Resident #2 and former Resident #1) reviewed for falls and/or potential abuse/neglect. Failure to follow the care plan placed Resident #1 and #2 at risk for injury. Findings include: 1. Closed record review revealed Resident #1 admitted to the facility with multiple medical diagnoses including [redacted] and [redacted]. Record review revealed the resident was on [redacted] care dated [redacted]/13. Review of the resident's care directives (instructions for caregivers) dated 9/12/13 revealed the resident required two staff for movement in bed. The resident was bed bound, had a specialty air mattress for pressure relief and the bed was positioned against the wall on the left side. Review of a facility investigation dated 9/24/13	F 282	***1. How corrective action accomplished for the identified residents?*** Resident #1 no longer resides in the facility. Resident #2's care directive have reviewed to validate that they are current. ***2. How you will identify other residents with the potential of being affected by the same practice?*** Residents who reside in the facility have the potential to be affected. ***3. Address what measures will be put in place to ensure deficient practice will not recur.*** Staff has been re-educated to follow care directives. Care directives have been audited to validate that interventions and devices are current and appropriate. Staff F has had re-education and disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505483	A. BUILDING _____ B. WING _____	C 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 revealed on that date, Resident #1 was receiving [redacted] care from Staff H (licensed nurse). Staff F (certified nursing assistant) was in the room to assist with positioning of the resident. Review of a witness statement from Staff H revealed she left the room to obtain additional supplies; while Staff H was out of the room, Staff F turned the resident to her side to change her at which time the resident rolled from the bed onto the floor. The resident sustained a 2.0 by 2.0 centimeter (cm) abrasion on her [redacted]. During interview on 10/17/13 at approximately 9:30 a.m., administrative Staff B clarified that Resident #1 was on her back when the nurse left the room; Staff F turned the resident away from her, towards the wall, without assistance from a second staff as required by the resident's care directive. 2. Record review revealed Resident #2 admitted with multiple diagnoses including history of a [redacted] Review of care directives revised and dated 9/11/13 revealed fall prevention interventions included a low bed, merry walker (seated device with wheels and a frame to hold onto while walking), sensor alarm on the bed and non-skid strips on the floor next to bed. Review of a facility investigation dated 10/3/13 at 3:50 a.m. revealed Resident #2 was attempting to get out of bed several times; Staff G (certified nursing assistant) placed the resident in a wheel chair and took her out of her room to the nurses' station for closer supervision. The resident fell from the wheel chair onto the floor and sustained abrasions to her forehead, nose and right leg (4 by 3 cm, 4 by 1 cm and 5 by 1 cm respectively).	F 282	***4. How will the plan be monitored to ensure the solutions are sustained?*** DNS will complete random audits of resident care to validate that care directives are being followed, weekly times one month and monthly times two. Finds will be brought to CQI for review and evaluation. ***5. Person responsible to validate compliance*** ED is responsible for compliance. Compliance date November 2, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505483	A. BUILDING _____ B. WING _____	C 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 Facility investigation determined Staff G did not follow the resident's care directives which directed staff to use a merry walker (implemented 1/23/13) and not a standard wheel chair. Observations of Resident #2 on 10/16/13 at 11:55 a.m. revealed the resident was properly positioned in a tilt in space (TIS) wheel chair. Attempted interview with the resident revealed she was not able to recall falling and not able to comment about her care. During interview at 12:15 p.m., Staff C (licensed nurse) and Staff D (certified nursing assistant) were aware of the change in care directives related to use of the TIS wheel chair. The change occurred as a result of a physical therapy evaluation initiated on 9/30/13 for an appropriate and safe seating system for Resident #2. The chair was available for use from therapy on 10/4/13.	F 282		